TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Midland Memorial Hospital

Respondent Name
Accident Fund General Insurance

MFDR Tracking Number
M4-17-2923-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
June 2, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the TDI/DWC fee schedule this account qualifies for an Outlier payment… The correct allowable due is $5,281.94 less their previous payment of $2,292.46, which leaves an outstanding balance of $2,989.46."

Amount in Dispute: $2,989.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor is not entitled to an outlier payment for any of the individual line item services that are separately payable because there are no services for which the total cost of the service exceeds both outlier thresholds."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2016	Outpatient Hospital Services	$2,989.46	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 181 – Payment adjusted because this procedure code was invalid on the date of service
   - 243 – Services not authorized by network/primary care providers

- 254 – The billed service has no allowance in fee schedule/UCR
- 56 – Significant, separately identifiable E/M service rendered
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 86 – Service performed was distinct or independent from other services performed on the same day
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 1014 – The attached billing was re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
- W3 – Additional payment made on appeal/reconsideration

Issues

1. Is the requestor's position supported?
2. Is additional reimbursement due to the requestor?

Findings

1. The requestor is seeking additional reimbursement in the amount of $2,989.46 for outpatient hospital services rendered on September 28, 2016. Their position statement submitted at the time MFDR was requested states, "Per the TDI/DWC fee schedule this account qualifies for an Outlier payment which is as follows: Outlier: Total APC Allowable x Cost to Chg Ratio = Hospital's Cost."

28 Texas Administrative Code 134.403 (b)(3) and (d) states,

> "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
>
> (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

The Medicare payment policy regarding outlier calculations is found in the Medicare claims processing manual, Chapter 4, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf states,

The current outlier payment is determined by:

> *• Calculating the cost related to an OPPS line-item service, including a pro rata portion of the total cost of packaged services on the claim and adding payment for any device with pass- through status to payment for the associated procedure, by multiplying the total charges for OPPS services by each hospital's overall CCR (see §10.11.8 of this chapter); and*
>
> *• Determining whether the total cost for a service exceeds 1.75 times the OPPS payment* ***and*** *separately exceeds the fixed-dollar threshold determined each year;*
>
> *• If total cost for the service exceeds both thresholds, the outlier payment is 50 percent of the amount by which the cost exceeds 1.75 times the OPPS payment.*
>
> *The total cost of all packaged items and services, including the cost of uncoded revenue code lines with a revenue code status indicator of "N", that appear on a claim is allocated across all separately paid OPPS services that appear on the same claim.* ***The proportional amount of total packaged cost allocated to each separately paid OPPS service is based on the percent of the APC payment rate for that service out of the total APC payment for all separately paid OPPS services on the claim.***

To illustrate, assume the total cost of all packaged services and revenue codes on the claim is $100, and the three APC payment amounts paid for OPPS services on the claim are $200, $300, and $500 (total APC payments of $1000). The first OPPS service or line-item is allocated $20 or 20 percent of the total cost of packaged services, because the APC payment for that service/line-item represents 20 percent ($200/$1000) of total APC payments on the claim. The second OPPS service is allocated $30 or 30 percent of the total cost of packaged services, and the third OPPS service is allocated $50 or 50 percent of the total cost of packaged services.

For 2016 the outlier payment thresholds is found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9486.pdf which states in pertinent part,

17 c. For hospital outlier payments under OPPS, there will be no change in the multiple threshold of 1.75 for 2016. This threshold of 1.75 is multiplied by the total line-item APC payment to determine eligibility for outlier payments

17 d. The fixed-dollar threshold increases in CY2016 relative to CY 2015. The estimated cost of service ***must be greater than the APC payment amount plus $3,250 in order to qualify for outlier payments.***

The requestor's calculation of the outlier payment does not meet the above Medicare reimbursement methodologies for the following reasons:

- The cost-to charge ratio for provider number 450133 found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending is "0.200" not the ".323" indicated in the requestor's position statement calculation

- The total allowable charges indicated in the position statement is $15,439.00. The calculation of the Medicare allowable per the applicable 2016 Addendums is $1,114.66 as indicated below:
  - Procedure code 86850 has status indicator Q1, denoting STV-packaged codes.
  - Procedure code 86900 has status indicator Q1, denoting STV-packaged codes.
  - Procedure code 86901 has status indicator Q1, denoting STV-packaged codes.
  - Procedure code 80053 has status indicator Q4, denoting packaged labs.
  - Procedure code 82150 has status indicator Q4, denoting packaged labs.
  - Procedure code 83690 has status indicator Q4, denoting packaged labs.
  - Procedure code G0480 has status indicator Q4, denoting packaged labs.
  - Procedure code 85025 has status indicator Q4, denoting packaged labs.
  - Procedure code 85610 has status indicator Q4, denoting packaged labs.
  - Procedure code 85730 has status indicator Q4, denoting packaged labs.
  - Procedure code 73590 has status indicator Q1, denoting STV-packaged codes.
  - Procedure code 73610 has status indicator Q1, denoting STV-packaged codes.
  - Procedure code 71010 has status indicator Q3, denoting packaged codes paid through a composite APC (if OPPS criteria are met) assigned APC 5521 with an allowable of **$60.80**.
  - Procedure code 99285 has status indicator J2, denoting hospital, clinic or emergency room visits (including observation/critical care services) subject to composite payment if certain other services are billed in combination. This is assigned APC 5025 with an allowable of **$486.04**.
  - Procedure code 96374 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This is assigned APC 5693 with an allowable of **$92.40**.
  - Procedure code 96375 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This is assigned APC 5692 with an allowable of **$42.31**.
  - Procedure code J0131 has status indicator N, denoting packaged codes.
  - Procedure code J1170 has status indicator N, denoting packaged codes.
  - Procedure code J1885 has status indicator N, denoting packaged codes.

- Procedure code Q9967 has status indicator N, denoting packaged codes.
- Procedure code 93005 has status indicator Q1, denoting STV-packaged codes.
- Procedure codes 70450, 72125, and 74177 have status indicator Q3, denoting packaged codes paid through a composite APC. This is assigned APC 8006 with an allowable of **$493.91**.

Based on the above the above the requestor's position statement is not supported.

2. The outlier calculation for the services in dispute is found below.

Total cost of all packaged services and revenue codes	APC	APC payment	Percent the APC payment for that service/line-item represents of total APC payments on the claim	Percent multiplied by total cost
$21,655.00	8006	$493.91	$493.91 / 1,114.66 = 0 .44	0.44 x $21,655.00 = $9528.20
$21,655.00	5025	$486.04	486.04 / 1,114.66 = 0.43	0.43 x $21,655.00 = $9311.65
$21,655.00	5693	$92.40	92.40 / 1,114.66 = 0.08	0.08 x $21,655.00 = $1732.40
$21,655.00	5692	$42.31	42.31 / 1,114.66 = 0.03	0.03 x $21,655.00 = $649.65
Total		$1,114.66		

APC	**Estimated cost** of service x 2016 Cost to Charge (0.200) rationale for facility	**Line – Item APC payment x 1.75**	**2016 Fixed -dollar threshold plus APC**
8006	$9528.20 x 0.200 = $1,905.64	$493.91 x 1.75 = $864.34	$3,250 + 493.91 = $3,743.91
5025	$9311.65 x 0.200 = $1,862.33	$486.04 x 1.75 = $850.57	$3,250 + 486.04 = $3,736.04
5693	$1732.40 x 0.200 = $346.48	$92.40 x 1.75 = $161.70	$3,250 + $92.40 = $3,342.40
5692	$649.65 x 0.200 = $129.93	$42.31 x 1.75 = $74.04	$3,250 + $42.32 = $3,292.32

As shown above, the estimated cost does not exceed **both** the line item payment x 1.75 and the 2016 fixed-dollar threshold amount plus the APC payment amount.

28 Texas Administrative Code 134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register.

As no outlier payment is due, no additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		June 30, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.